REVIEW OF

COMMUNITY RESIDENTIAL SERVICES FOR ADULTS WITH MENTAL RETARDATION

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Office of the Inspector General
For Mental Health, Mental Retardation
And Substance Abuse Services

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Inspector General

Report #126-05

Office of the Inspector General
Review of Community Residential Services
For Adults with Mental Retardation

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Section I

Office of the Inspector General
Review of Community Mental Retardation Residential Services

Executive Summary

The Office of the Inspector General for Mental Health, Mental Retardation & Substance Abuse Services (OIG) conducted a statewide review of group homes and sponsored family placements for adults with mental retardation during November and December 2005. Community-based residential services were selected for inspection for a number of reasons. These services are provided 24 hours a day with limited availability of supervision and serve approximately 2500 adults with mental retardation, many of whom have severe disabilities and medical needs. Significant funding, primarily Medicaid, is expended for these services annually, and many citizens are on waiting lists for these programs.

To assure that the review focused on current issues, the OIG invited the contribution of ideas from a wide range of stakeholders including family members, community and state training center providers, advocates and the staff of Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS). The basis for the review was six Quality Statements for Mental Retardation Residential Services that were developed by the OIG and are included as Appendix A. The methodology for the review involved the random selection of a representative sample of public and private providers and unannounced inspection visits to 75 homes located in all areas of Virginia. OIG staff reviewed 244 consumer records (75 received intensive review) and conducted interviews with 64 residents, 71 direct care staff, 68 supervisors or managers of provider agencies, 66 case managers, and 57 family members or authorized representatives.

Findings and Recommendations

The findings from this review have been organized into two groupings – findings related to the **Demographics of Service Recipients** and findings and recommendations dealing with **Quality of Care**.

Demographics of Service Recipients

Demographic Finding 1: The majority of all residents, 54 %, are between ages 22 and 45. Thirty-seven % are between ages 46 – 65, and only 4 % are over 65 years of age. Publicly operated programs serve a higher proportion (59%) of older residents, 46 years of age and older, than do privately operated programs (33%).

Demographic Finding 2: A significantly greater proportion of the residents receiving community residential services are males (66%). Private providers serve a somewhat higher percentage of males (71%) as compared to 53% in publicly operated homes.

Demographic Finding 3: The highest proportion of community residents (41%) have moderate levels of retardation, followed by 28 % with severe mental retardation, 22% with mild mental retardation and 10% with profound mental retardation. Public providers serve a slightly higher proportion of persons with severe to profound levels of mental retardation (43%) as compared to private providers (36%).

Demographic Finding 4: Approximately 25% of individuals served in community residences have at least one co-occurring psychiatric diagnosis in addition to mental retardation. A mood disorder is the most common co-occurring psychiatric disorder (25%), followed by psychotic disorder (18%) and anxiety disorder (17%). Many individuals have more than one co-occurring psychiatric disorder.

Demographic Finding 5: Some level of mobility support is needed by 29% of residents who live in group homes and sponsored family placements. Thirteen percent require extensive assistance or are totally dependent on others for mobility. Where needed, accessibility modifications have been made to the homes in which residents with special mobility needs live.

Demographic Finding 6: The level of functioning of consumers in community residences as determined by the Level of Functioning (LOF) scale which is required by the Department of Medical Assistance Services (DMAS) and administered by the CSB case manager is as follows:

- Four areas of need - 27%
- Five areas of need - 24%
- Six areas of need - 18%
- Three areas of need -17%
- Two areas of need - 10%
- Seven areas of need - 4%

No significant differences exist between public and private providers in terms of the consumer level of functioning as assessed using the LOF. Note: The LOF assesses need in the following seven areas: health status, communication, task learning skills, personal/self care, mobility, behavior, and community living skills

Quality of Care Findings and Recommendations

A. Health and Safety

Health and safety are fundamental building blocks of a quality program. Family members rate health and safety as their primary concern, followed only by their desire that their family member be happy (DMHMRSAS annual family survey).

Quality of Care Finding A.1: Community programs assure access to health care for most residents despite limited sources of reimbursement for these services.

Quality of Care Recommendation A.1: It is recommended that the Department of Medical Assistance Services (DMAS) investigate the cost and feasibility of covering dental services for adults receiving Mental Retardation Medicaid Waiver services.

Quality of Care Finding A.2: Health care is not well coordinated and integrated for residents of some residential programs.

Quality of Care Recommendation A.2.a: It is recommended that DMHMRSAS initiate a collaborative effort with DMAS, CSBs and private providers to develop model forms, procedures, and other resources to help community providers assure more thorough health assessments and better coordination and integration of health care assessments and services.

Quality of Care Recommendation A.2.b: It is recommended that community residential service providers use the services of psychiatrists for consultation or direct services whenever possible for persons with co-occurring disabilities of mental retardation and mental illness or behavioral conditions that may require psychotropic medications.

Quality of Care Finding A.3: Community residential programs are generally clean and safe.

No recommendations

B. Choice and Self-Determination

The essence of freedom is the opportunity to choose. DMHMRSAS has established choice and self-determination as critical variables to guide the statewide system of care for persons with mental disabilities.

Quality of Care Finding B.1: The majority of community residents have a high degree of choice in activities and participation in community residential programs.

No recommendations

Quality of Care Finding B.2: Residents are afforded opportunities for choice and self-determination in most aspects of daily living, but less evidence is found of significant choice in the development of service plans.

Quality of Care Recommendation B.2.a: It is recommended that DMHMRSAS initiate a collaborative effort with CSBs, private providers and the training centers to develop a model system for person-centered, consumer driven planning with related procedures, forms and resource materials. It is further recommended that these materials be made available to all public and private community providers and to the five training centers.

Quality of Care Recommendation B.2.b: It is recommended that DMHMRSAS initiate a collaborative effort with CSBs, private providers and the training centers to develop an ongoing training program on person-centered planning, choice, self-determination, and the role of staff as supporters and teachers of learning and that the training program be available free or at low cost to CSB's, private providers and training centers and regional consortia.

Quality of Care Recommendation B.2.c: It is recommended that DMHMRSAS revise licensure requirements for group home and sponsored family placements to require certification by the provider that each staff member has completed training in person-centered planning, choice, self-determination, and the role of staff as supporters and teachers of learning using an approved training module.

C. Community participation and integration

Along with choice, community integration – for work, shopping, and recreation - is a major component of good quality of life. The formation of valued relationships with persons in the community - other than those paid to work with the residents - is key.

Quality of Care Finding C.1: All community-based residents have frequent and regular activities away from their homes and out in the community for work, shopping, and recreation.

No recommendations

Quality of Care Finding C.2: Smaller residences, especially sponsored placements, have better levels of community participation for residents than larger group homes.

No recommendations

Quality of Care Finding C.3: While all homes help residents get out to the community for work, shopping, church, recreation and other activities, reliance in group homes on group activities decreases the opportunities for true integration and formation of valued relationships with people other than paid staff.

Quality of Care Recommendation C.3: It is recommended that DMHMRSAS initiate a study with DMAS, CSBs and private providers to determine the optimal size, characteristics, and staffing patterns of residential programs that have been found to be effective in promoting full integration of residents into the community and good quality of life. This study should identify what changes in state policy and funding would be required to support the widespread development of such programs in Virginia.

D. Culture of support for growth and development

Good quality of life requires community living skills. Effective residential services provide training that enhances and grows these skills to enable the highest level of

independence possible. Staff practices that teach and support residents to master skills are valued over approaches that provide static care, no matter how loving. Training programs should be based on thorough assessments of skills needed to live more independently. Staff should have personal interest in and knowledge of the persons for whom they provide supports.

Quality of Care Finding D.1: While a significant number of staff in group homes and community placements interact with residents as teachers and supporters of learning, the majority relate as caretakers or supervisors.

Quality of Care Recommendation D.1: It is recommended that each CSB and private provider of residential services review it's mission statement and value statements and make any changes needed to assure consistency with the system wide vision statement adopted recently by DMHMRSAS. Once this is done, each CSB and private provider should take the necessary steps to assure that the actions of staff at all levels and the culture of the program reflect the organizational mission and value statements.

Quality of Care Recommendations B.2.a, B.2.b and B.2.c are in support of this finding.

Quality of Care Finding D.2: Residents are treated with dignity and respect.

No recommendations

Quality of Care Finding D.3: Staff and provider agencies show interest in the residents and are committed to their work.

No recommendations

Quality of Care Finding D.4: The comprehensiveness and quality of residents' needs assessments and service plans varies considerably among community residential providers. Many plans and activities are not clearly directed at improved quality of life and greater independence for residents.

Quality of Care Recommendation D.4.a: It is recommended that DMHMRSAS initiate a collaborative study with CSBs and private providers to:

- Define and quantify the staff resources that are needed to support adequate interdisciplinary assessment and planning for the residents of public and private community-based residential services.
- Develop models for how these services can be delivered collaboratively by CSBs, private providers, training centers, and/or universities.

Quality of Care Recommendation D.4.b: Based on the results of this study, it is recommended that:

- Individual public and private providers and regional groups of public and private providers identify ways in which current resources can be redirected to provide interdisciplinary planning and assessment staffing.
- DMHMRSAS request sufficient funding to support these services.

Quality of Care Recommendations B.2.a and B.2.b. are in support of this finding.

Quality of Care Finding D.5: Providers and direct support staff have appropriate education, experience, and longevity to support quality services.

No recommendations

E. Comfort and Privacy

Comfortable, attractive homes are essential to good quality of life. Privacy, space to one's self, and personal decorations and furnishings are key components. A private bedroom for each person is highly desirable, unless specific, resident-generated choices are for shared living arrangements.

Quality of Care Finding E.1: Community residential programs are comfortable and attractively furnished.

No recommendations

Quality of Care Finding E.2: Most community group homes and sponsored placements have a satisfactory level of privacy for residents.

No recommendations

F. Assurance of accountability and oversight

Families and taxpayers should have assurances that publicly funded services for persons with mental retardation and related needs are safe, compliant with regulatory and funding source requirements, and deliver quality services.

Quality of Care Finding F.1: Oversight activity at group homes and sponsored placements by state oversight offices/agencies is limited due to staffing constraints.

Quality of Care Recommendation F.1.a: It is recommended that DMHMRSAS and DMAS continue to request resources to expand staffing in their respective oversight offices in order to assure regular and timely inspections of all licensed providers.

Quality of Care Recommendation F.1.b: It is recommended that as DMHMRSAS and DMAS review and amend their respective regulations and inspection procedures that they seek ways to:

- Incorporate the vision and values that have been established by DMHMRSAS for the system of care.
- Expand the focus of oversight activities related to assessment of consumer quality of life.
- Assure consistency between the regulations and procedures of the two agencies.
- Streamline and minimize data and record keeping requirements in an effort to allow providers to maximize the amount of time that staff is available to consumers.

Quality of Care Finding F.2: Many CSB case managers do not make regular visits to consumers in their group homes or sponsored family placement settings.

Quality of Care Recommendation F2: It is recommended that CSB case managers visit with their consumers in the group home or sponsored family placement setting on a regular basis and make an assessment of:

- The services provided by the provider.
- The quality of life of the consumer.

Section II

Background of the Study

About the Office of the Inspector General

The Office of the Inspector General (OIG) is established in the VA Code § 37.2-423 to inspect, monitor and review the quality of services provided in the facilities operated by the Department of Mental Health, Mental Retardation & Substance Abuse Services (DMHMRSAS) and providers as defined in § 37.2-403. This definition includes all providers licensed by DMHMRSAS including community services boards (CSB) and behavioral health authorities (BHA), private providers, and mental health treatment units in Department of Correction facilities. It is the responsibility of the OIG to conduct announced and unannounced inspections of facilities and programs. Based on these inspections, policy and operational recommendations are made in order to prevent problems, abuses, and deficiencies, and improve the effectiveness of programs and services. Recommendations are directed to the Office of the Governor, the members of the General Assembly and the Joint Commission on Healthcare.

Selection of Community-Based Residential Services for Review

Community group home and sponsored family placement services for adults with mental retardation were selected by the OIG for review for the following reasons:

- Residential services offer care and supervision 24 hours a day with limited availability of supervision and consultation to direct care staff much of the time. Currently, approximately 2300 individuals are served in group homes and approximately 200 in sponsored placements. Many of these individuals have severe disabilities and medical needs.
- Residential services for adults with mental retardation have expanded rapidly over the past 15 years and further expansion is expected due to significant waiting lists. Significant funding, primarily Medicaid, is expended for these services.
- Virginia has declared the intent to move to a community-focused system of services and to continue downsizing the state operated training centers. The provision of residential services is a key element in the conversion from an institution-based model to a community-based model of services. Debate about the desired balance of state and community residential programs is continuous and intense.
- Community service providers, advocates, and persons with mental retardation seek funding annually from the Virginia General Assembly for expanded community residential options.
- Family members of persons served in Virginia's five state training centers have expressed concerns about the adequacy of community-based programs to meet the needs of their sons and daughters. Concerns include:
    - Adequacy of health care

    - Qualifications of provider agencies and of staff
    - Performance of community-based services
- Disputes exist among advocates and program experts about the ideal size and design of community programs. Advocates at the national and state levels and some state mental retardation authorities now reject group home models and call for community programs of no greater than three residents in one setting.
- Little data exists about the residents served in community group homes and sponsored family placements in Virginia.
- In spite of oversight by multiple state and local agencies, reports of incidents of abuse, neglect and licensure violations remain a source of concern and interest.

Design of the Review

The OIG began the study process by conducting an extensive literature search of indicators of quality in mental retardation residential services, as seen by persons who receive such services, program experts, academics, standard-setting organizations, family members, advocates, etc. In addition, and in the fashion of previous OIG studies, input was sought on residential service quality indicators, concerns and issues from a wide variety of Virginia providers, stakeholders, and family members through a series of teleconferences and meetings in September and October 2005. Input to the design of the review was received from the following groups:

> DMHMRSAS leadership and central office staff (including the Office of Licensure and Office of Human Rights), DMHMRSAS facility directors, The Arc of Virginia, PAIR, the Mental Retardation Special Populations Work Group, the Virginia Network of Private Providers, Community Services Boards (executive directors and mental retardation services directors), and the Department of Medical Assistance Services (DMAS).

The OIG developed a set of 6 Quality Statements with 34 quality indicators for Residential Services for Persons with Mental Retardation from the research and input described above. The Quality Statements for Residential Services are as follows: (The 34 detailed quality indicators can be found in Appendix A.)

1. The home is safe, clean, attractive, and comfortable.
2. Preventive, acute and chronic health needs of residents are met in a thorough, comprehensive, and safe manner.
3. Residents have choice and self-determination in all aspects of their lives.
4. Residents enjoy a high level of community participation.
5. Residents are supported to learn the skills they need to achieve their goals and participate in the community at the highest level of quality of life possible.
6. Accountability for not only compliance with standards but also the quality of services is assured.

Review population and selection of samples

The quality of life experienced by the persons served in community-based residential programs was an important focus of this review. The objective was to evaluate services from the perspective of a representative sample of residents. It was decided to create two levels of study - a larger sample of residents for a general review and a smaller sample for an intensive level of study. The larger sample, which was selected at random, received a record-based analysis that emphasized descriptive data. The smaller sample, which was a subset of the larger sample, received more intensive study. This consisted of a detailed inspection of the clinical record, an unannounced inspection of the individual's living site, an interview of the resident, as well as interviews with staff, family or authorized representative (AR), case manager, and provider representatives.

At the start of the review there were approximately 729 group homes licensed to serve adults with mental retardation, operated by 167 public (CSB) and private providers. The number of sponsored family home placements and the number and names of persons served in these settings is not maintained centrally. Information is only available about the licensed providers of this service, of which there were 21 at the start of the study.

Many providers operate only one group home, but most operate multiple sites (some as many as 30 or more residences). In order to fully represent the preponderance of placements, it was decided that every provider offering more than five sites would have at least one home selected at random. Those providers with 20 or more homes had two homes selected at random. A random selection was then made of the remaining, smaller providers. A total of 62 group homes was selected, along with 13 sponsored placement sites. A list of the selected providers has been provided in Appendix B.

Since there was no way to draw a sample of individuals before the unannounced arrival at the community residences, OIG staff made random selections of consumers for the review once arriving at the homes. A maximum of four persons per residence were selected for review. One of these individuals was then selected randomly for intensive study.

In the community review, 244 residents were selected for the overall review, with a subset sample of 75 selected for intensive review. In the sample, 66 % of the providers were private providers and 33 % were community services boards, which is the same distribution as is represented in 100% of the providers. A thorough geographic distribution was obtained by random selection. This selection covered all sections of the Commonwealth and reflected both population concentrations and the location pattern of the residences.

Development of survey instruments

OIG staff developed structured interview instruments that addressed each of the indicators in the quality statements, many from more than one point of view. Where possible, these interview instruments were based on questionnaires or other evaluation

tools found in the professional and consumer literature or tools that had been used before in Virginia. Examples of existing Virginia survey instruments that were sampled include the DMHMRSAS Family Satisfaction Survey and the survey instruments developed by the Citizens' Monitoring Program, a family-driven mental retardation quality survey team sponsored by the Virginia Beach Community Services Board.

All survey questionnaires and checklists can be found in Appendix D in the version of the report that is located on the OIG website (www.oig.virginia.gov).

Process of the review

All licensed providers of group home and sponsored placements received a letter from the Inspector General in October 2005 announcing the review and informing them that their site(s) may be selected for inspection. Providers were asked to inform families that these visits would take place. Case management supervisors at the CSBs were also informed of the review by letter.

In November and December 2005, OIG staff visited the community group homes and sponsored placements. All visits were unannounced. Because sponsored placement residents live in family homes, these providers received a courtesy call 15 minutes before the inspector arrived.

- Field inspections of group homes averaged 2 hours each, usually with a single OIG inspector. Visits occurred on weekends, early weekday mornings, and weekday evenings when residents were more likely to be at home.
- 244 clinical records were reviewed. Of these, 73 records at the community programs received intensive reviews and cross analysis with interview findings.
- 64 consumers were interviewed in community programs.
- 71 direct service staff members were interviewed.
- 66 CSB case managers were interviewed.
- 57 family members or authorized representatives were interviewed.
- 68 provider representatives were interviewed (owners, executive directors, residential care supervisors, etc.).

The inspection review teams included OIG staff members Heather Glissman, Cathy Hill, John Pezzoli and Jim Stewart and part-time consulting staff Judy Dudley, Karen O'Rourke, Jonathan Weiss and Ann White. DMHMRSAS staff, Sanford Hostetler and Diane Marsiglia, assisted with data base design, and data entry assistance was provided by Stevie Burcham and Sheena Meritte. John Pezzoli served as Project Manager for this review.

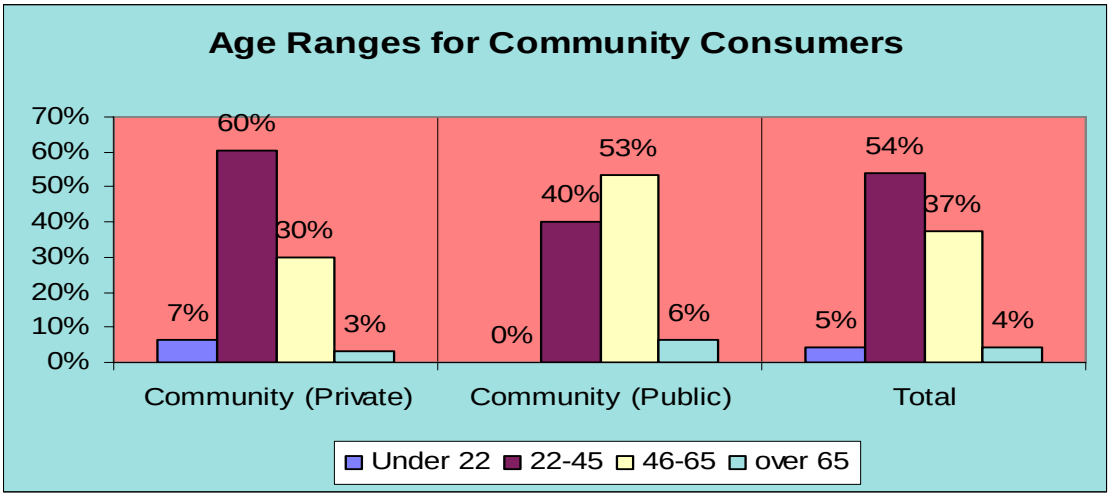
Section III

Service Recipient Demographic Findings

Data were collected for 244 residents of community group homes and sponsored family placements. The source of data was individual service records reviewed at 75 homes in Virginia. Of those for whom information was collected, 167 persons reside in homes operated by private sector providers and 77 persons reside in homes operated by CSBs.

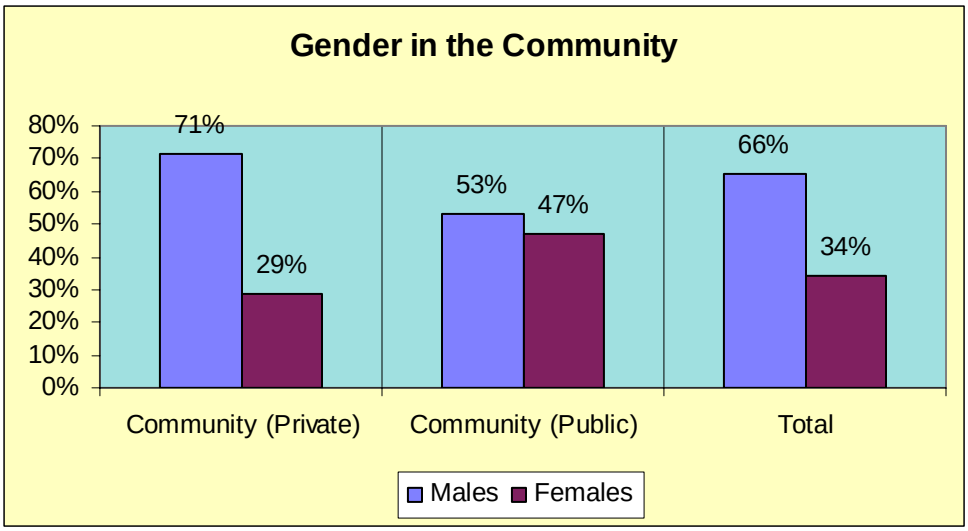
Demographic Finding 1: The majority of all residents, 54 %, are between ages 22 and 45. Thirty-seven percent are between ages 46 – 65, and only 4 % are over 65 years of age. Publicly operated programs serve a higher proportion (59%) of older residents, 46 years of age and older, than do privately operated programs (33%).

Community Consumers by Age								
	Under 22		22-45		46-65		over 65	
Community (Private)	11	7%	101	60%	50	30%	5	3%
Community (Public)	0	0%	31	40%	41	53%	5	6%
Total	11	5%	132	54%	91	37%	10	4%



Demographic Finding 2: A significantly greater proportion of the residents receiving community residential services are males (66%). Private providers serve a somewhat higher percentage of males (71%) as compared to 53% in publicly operated homes.

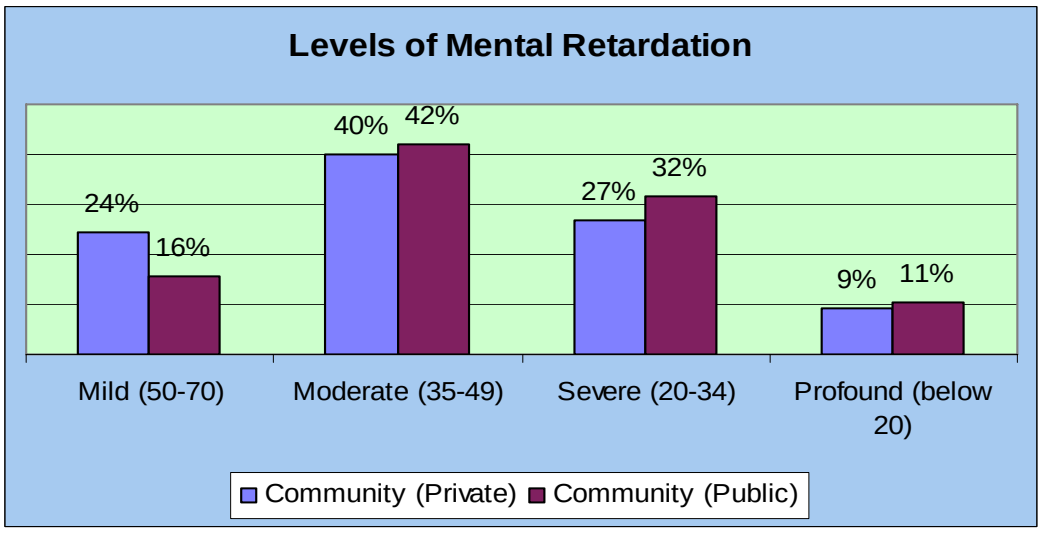
Gender in the Community				
	Males		Females	
Community (Private)	119	71%	48	29%
Community (Public)	41	53%	36	47%
Total	160	66%	84	34%



Demographic Finding 3: The highest proportion of community residents (41%) have moderate levels of retardation, followed by 28 % with severe mental retardation, 22% with mild mental retardation and 10% with profound mental retardation. Public providers serve a slightly higher proportion of persons with severe to profound levels of mental retardation (43%) as compared to private providers (36%).

LEVELS OF MENTAL RETARDATION FOR COMMUNITY CONSUMERS

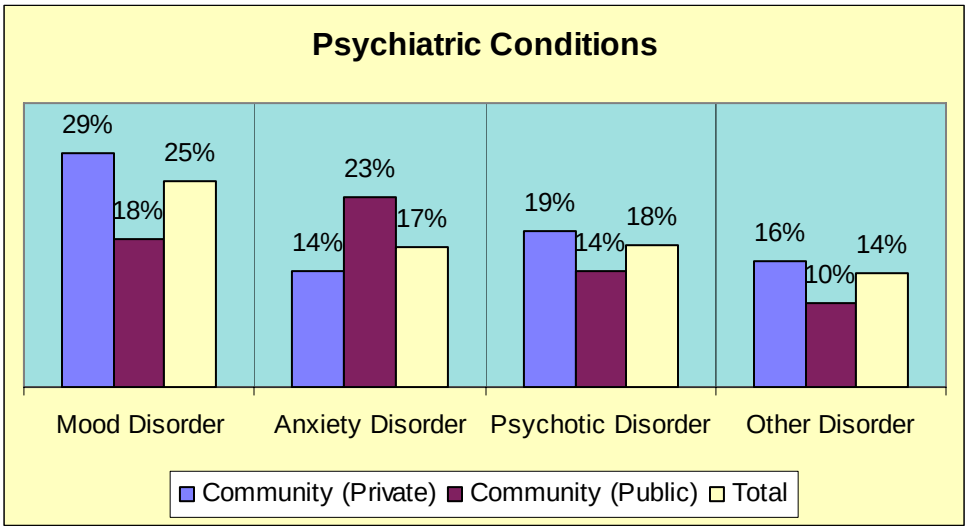
	Mild (50-70)		Moderate (35-49)		Severe (20 -34)		Profound (below 20)	
Community (Private)	**40**	**24%**	**66**	**40%**	**44**	**27%**	**15**	**9%**
Community (Public)	**12**	**16%**	**32**	**42%**	**24**	**32%**	**8**	**11%**
Total	**52**	**22%**	**98**	**41%**	**68**	**28%**	**23**	**10%**



Demographic Finding 4: Approximately 25% of individuals served in community residences have at least one co-occurring psychiatric diagnosis in addition to mental retardation. A mood disorder is the most common co-occurring psychiatric disorder (25%), followed by psychotic disorder (18%) and anxiety disorder (17%). Many individuals have more than one co-occurring psychiatric disorder.

PSYCHIATRIC CONDITIONS IN COMMUNITY CONSUMER SAMPLE

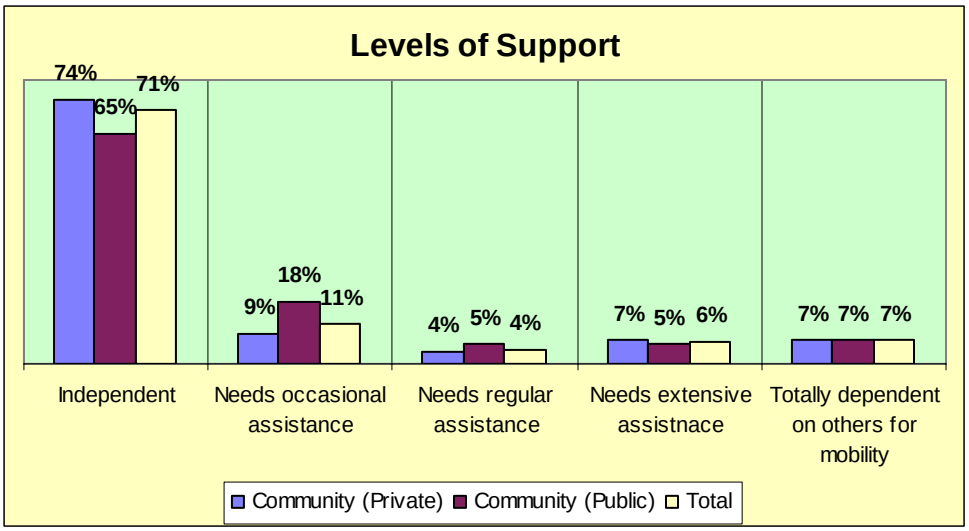
	Mood Disorder		Anxiety Disorder		Psychotic Disorder		Other Disorder	
Community (Private)	48	29%	24	14%	32	19%	26	16%
Community (Public)	14	18%	18	23%	11	14%	8	10%
Total	62	25%	42	17%	43	18%	34	14%



Demographic Finding 5: Some level of mobility support is needed by 29% of residents who live in group homes and sponsored family placements. Thirteen percent require extensive assistance or are totally dependent on others for mobility. Where needed, accessibility modifications have been made to the homes in which residents with special mobility needs live.

LEVELS OF SUPPORT NEEDED FOR MOBILITY

	Independent		Needs occasional assistance		Needs regular assistance		Needs extensive assistance		Totally dependent on others	
Community (Private)	122	74%	14	9%	6	4%	11	7%	11	7%
Community (Public)	48	65%	13	18%	4	5%	4	5%	5	7%
TOTAL	170	71%	27	11%	10	4%	15	6%	16	7%



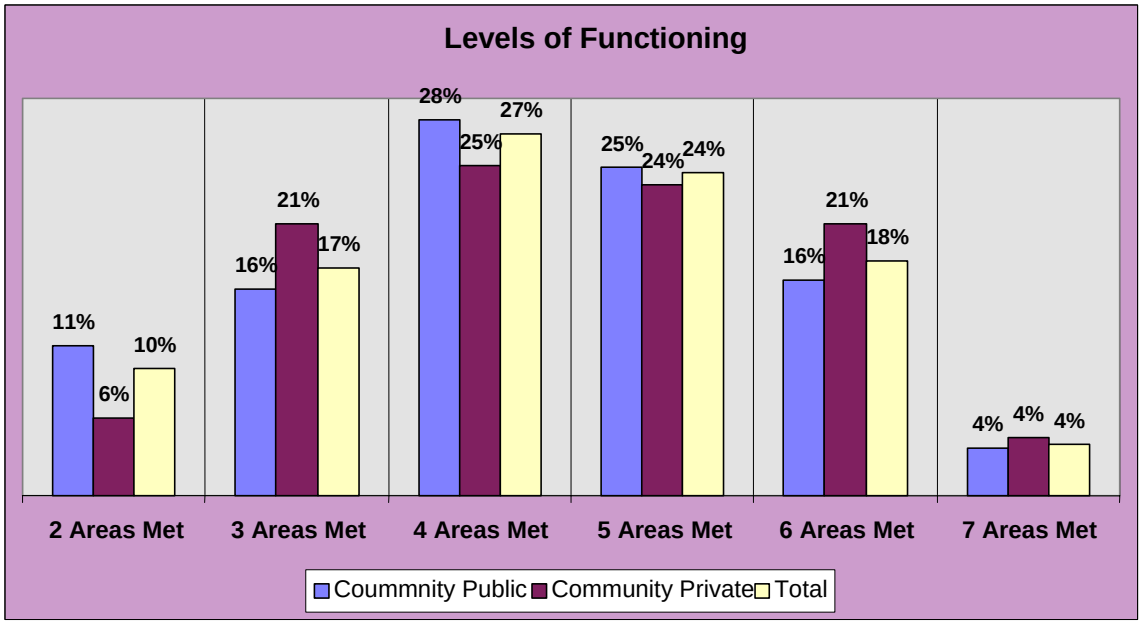
Demographic Finding 6: Level of Functioning: To be eligible for Medicaid waiver funding, residents must demonstrate significant support needs in at least two areas on the Level of Functioning (LOF) scale administered by CSB case managers. The scale measures:

- health status
- communication
- task learning skills
- personal/self care
- mobility
- behavior
- community living skills

The largest proportion of community residents, 27 %, meet four areas of support need, followed by five areas of need (24%), 6 areas of need (18%), three areas of need (17%), two areas of need (10%) and seven areas of need (4%). No significant differences exist between public and private providers in terms of the level of functioning of residents served.

LEVELS OF FUNCTIOING FOR COMMUNITY CONSUMER SAMPLE

	2 Areas Met		3 Areas Met		4 Areas Met		5 Areas Met		6 Areas Met		7 Areas Met	
Community (Private)	**16**	**11%**	**22**	**16%**	**40**	**28%**	**35**	**25%**	**23**	**16%**	**5**	**4%**
Community (Public)	**4**	**6%**	**14**	**21%**	**17**	**25%**	**16**	**24%**	**14**	**21%**	**3**	**4%**
Total	**20**	**10%**	**36**	**17%**	**57**	**27%**	**51**	**24%**	**37**	**18%**	**8**	4%


Levels of Functioning
11%
6%
10%
16%
21%
17%
28%
25%
27%
25%
24%
24%
16%
21%
18%
4%
4%
4%
2 Areas Met
3 Areas Met
4 Areas Met
5 Areas Met
6 Areas Met
7 Areas Met
Coummnity Public
Community Private
Total

Section IV

Quality of Care Findings and Recommendations

A. Health and Safety

Health and safety are fundamental building blocks of a quality program. Family members rate health and safety as their primary concern, followed only by their desire that their family member be happy (DMHMRSAS annual family survey).

Quality of Care Finding A.1: Community programs assure access to health care for most residents despite limited sources of reimbursement for these services.

- 81 % of resident records show residents receive periodic health checkups and acute medical care with timely follow up and comprehensive records; 11 % show adequate but less complete coverage; and 7 % of records were judged to show incomplete or inadequate healthcare.
- The storage, handling, and documentation of medications were assessed at each residence. Only 2 % of homes were noted to have discrepancies in storing and providing medications.
- Almost all community residents were found to have received dental care in the last year. 28 % of providers noted lack of reimbursement for dental costs as a problem that needs attention. Medicaid does not cover dental care. Providers find creative ways to fund dental care: donated care, long term payments from residents' funds, provider agency support, and access to free community services. Podiatry, vision care, physical therapy, occupational therapy, and nursing were also noted as inadequately reimbursed.

Quality of Care Recommendation A.1: It is recommended that the Department of Medical Assistance Services (DMAS) investigate the cost and feasibility of covering dental services for adults receiving Mental Retardation Medicaid Waiver services.

DMAS Response: *DMAS will include this recommendation in its upcoming study/review of the MR Waiver to begin in the summer of 2006.*

Quality of Care Finding A.2: Health care is not well-coordinated and integrated for residents of some residential programs.

- Community group homes obtain health care for residents from a variety of separate community providers: general practitioners, psychiatrists, medical specialists, and dentists. In this regard, medical care for group home residents is comparable to that received by non-disabled Americans – and different than that received by residents of state training facilities, which is provided in one location, by a team of interdisciplinary providers. Concerns exist for some community programs about integration of medical care, analysis of medication interactions, and overall review of healthcare coordination by medically competent personnel.

- A limited number of healthcare assessments were noted to be less comprehensive and thorough than desirable.
- In some community residences, general practitioners prescribe psychiatric medications rather than psychiatrists. This often occurs without a comprehensive psychiatric evaluation and diagnosis.

Quality of Care Recommendation A.2.a: It is recommended that DMHMRSAS initiate a collaborative effort with DMAS, CSBs, and private providers to develop model forms, procedures, and other resources to help community providers assure more thorough health assessments and better coordination and integration of health care assessments and services.

DMHMRSAS Response: *DMHMRSAS will convene a work group made up of DMAS officials, VACSB, and private providers to explore the issues of improving the coordination and integration of quality health care. The results of this work group will be:*

1. *Development of a standardized health assessment to be implemented in all programs licensed by DMHMRSAS;*
2. *Development of language to be inserted in the licensure regulations (subject to all normal procedure of the regulatory change process) relative to minimum requirements for coordination and integration of health care practices.*
3. *Explore other options and make further recommendations to the DMHMRSAS designed to improve the overall quality of the assessment, coordination, and integration of health care for persons living in licensed community residential programs.*

Quality of Care Recommendation A.2.b: It is recommended that community residential service providers use the services of psychiatrists for consultation or direct services whenever possible for persons with co-occurring disabilities of mental retardation and mental illness or behavioral conditions that may require psychotropic medications.

DMHMRSAS Response: *DMHMRSAS will continue to develop the capacity for qualified services in the community for individuals diagnosed with co-occurring disabilities of mental illness and mental retardation (MI/MR) so that any use of psychotropic medications is under the supervision of the most qualified professional available. To this end, DMHMRSAS will:*

1. *Work with the Partnership for People With Disabilities in developing qualified PBS behavioral consultants who can help monitor the referral process to the most appropriate physicians prescribing medications and help advise treating physicians on the indications of the prescribed medications. A total of 70 new behavioral consultants will be trained and endorsed, for practice in the community, by December 2007.*

2. *Develop expertise through the state training centers' new Regional Community Support Centers to provide the qualified expertise in prescription medication monitoring and management for individuals with MI/MR living in the community. Three training centers have now developed RCSCs, with the goal of developing an RCSB in each training center.*
3. *Continue to work with the CSBs in prioritizing the need for expanded psychiatric support services and utilize this information in preparing community-based budget initiatives.*

Quality of Care Finding A.3: Community residential programs are generally clean and safe.

- Of the 75 homes visited, the vast majority was found to be clean, well maintained, and attractive. 73 % of group homes and sponsored placements receiving unannounced visits were found to be clean and well maintained. 20 % were judged to have minor deficiencies. Only 7 % were judged to be dirty or poorly maintained.
- All respondents (the residents themselves, their parent or authorized representative, direct support staff at the home, a supervisor or director of the provider organization, and the case manager) said residents are safe and protected from harm.
- Virtually no direct support staff reported that they felt unsafe working in community residences.

No recommendations

B. Choice and Self-Determination

The essence of freedom is the opportunity to choose. DMHMRSAS has established choice and self-determination as critical variables to guide the statewide system of care for persons with mental disabilities.

Quality of Care Finding B.1: A majority of community residents have a high degree of choice in activities and participation in community residential programs.

- 59 % of homes were judged to offer the residents' choice of activities, meals, snacks, bedtime, and participation level. 38 % offer more limited choice, for certain decisions, some of the time. In 3 % of programs there is little evidence of choice.
- The highest levels of choice and expression of preferences is found in sponsored family placements.
- Residents who were able to answer questions about choice generally responded positively about such options as staying up late, getting snacks, etc.
- Meal selection is an area where group home residents enjoy significant choice, at least on a family-style basis. 51 % of staff said meal choice is up to the residents; 45 % said the program prepares menus after some resident choice and input. Only 4 % said meal choice is by staff or a dietician

- OIG staff observed direct support staff in interaction with residents. Almost all staff was observed to comfortably and naturally offer choices in most home and community routines.

No recommendations

Quality of Care Finding B.2: Residents are afforded opportunities for choice and self-determination in most aspects of daily living, but less evidence is found of significant choice in the development of service plans.

- Provider interviews showed that 77 % of programs offer consumers choices about where they live and whether or whom they might have for a roommate. 23 % said they try to accommodate such choices but do not always find it possible (usually due to lack of vacancies).
- 46 % of families and 40 % of case managers said they had enough choice among providers in selecting residences for their family member. Many said their choice of a home was the only vacancy or the only program that would accept the person.
- Of those able to answer, 53 % of residents said they had chosen to live in their residence.
- Most families and case managers said that residents "get enough say" in developing their own plans and activities.
- Very few programs demonstrated "state of the art" person-centered, consumer-directed service plans. A limited number of programs used specially designed sections or forms to reflect the efforts and techniques used to elicit consumer preferences.
- Persons with very severe disabilities were often described by staff as not being capable of meaningfully participating in their program plans. Participation was often limited to presence at the annual planning session or documented assent to the plan.
- A limited number of homes documented planful and sensitive techniques to assess, elicit, or infer resident choice, based on observation and team discussion of the person's behaviors, reactions, and signals.
- No instances of advanced forms of person-directed control of services (staff selection, choice of services, allocation of service funds, etc.) were noted in any setting.

Quality of Care Recommendation B.2.a: It is recommended that DMHMRSAS initiate a collaborative effort with CSBs, private providers and the training centers to develop a model system for person-centered, consumer driven planning with related procedures, forms and resource materials. It is further recommended that these materials be made available to all public and private community providers and to the five training centers.

DMHMRSAS Response: *DMHMRSAS, in collaboration with DMAS as the lead agency, and other public entities is applying for the CMS Systems Transformation Real Choice Grant due June 15, 2006. One of the goals of the grant proposal is the*

development of persons-centered methodology and training for Virginia's system of supports. Grantees will be notified in July for awards beginning in September. This initiative will allow for federal dollars to fund the development of person centered objectives and training throughout the Commonwealth over the next five years.

The Office of Mental Retardation has been working with the Partnership for People with Disabilities in a CMS Re-Balancing Grant aimed at furthering the practice of person centered planning statewide. The project is currently working at two sites, Virginia Beach CSB and Region Ten CSB, piloting materials, a person-centered planning format, and training curriculum on person centered training developed by recognized national leaders in the field of person-centered planning. Several members of the OMR Training and Technical Assistance Team are participating in the pilot sites, learning the process to share with CSBs, private providers, and the training centers.

The DMHMRSAS is committed to developing this system for person-centered, consumer driven planning regardless of our success with securing the CMS Real Choice Grant. This commitment extends to the inclusion of the public and private provider networks. The DMHMRSAS will have a comprehensive statewide plan for person centered training, including related procedures, forms and resource material developed by January 1, 2007.

Quality of Care Recommendation B.2.b: It is recommended that DMHMRSAS initiate a collaborative effort with CSBs, private providers and the training centers to develop an ongoing training program on person-centered planning, choice, self-determination, and the role of staff as supporters and teachers of learning and that the training program be available free or at low cost to CSB's, private providers and training centers and regional consortia.

DMHMRSAS Response: *A special Positive Behavioral Supports (a person centered behavioral approach) initiative has begun with the Partnership for People With Disabilities and DMHMRSAS to train and endorse 70 new providers in the practice of Positive Behavioral Supports who will be able to practice both in the community and the facilities over an 18 month period beginning July 1, 2006.. This effort will introduce and reinforce person centered and positive behavioral support principles to line staff in all services where these new practitioners will serve.*

The development of the person centered training curriculum will follow a "train the trainer" formula, allowing agencies to self-perpetuate the training to new employees and to reinforce the principles through repetition by staff who are rotating into roles of trainer following their initial training. Initiation of this training will begin by January 1, 2007 and DMHMRSAS will ensure that all training material is made available to the public and private provider network.

The College of Direct Supports, initiated through DMHMRSAS in 2006 and already available among many CSBs, training centers, and community providers contained a

web-based training program with a person-centered planning module. The DMHMRSAS will continue to promote the use of this avenue of training to the providers in the Commonwealth. It is already allowed as a substitute for the required MR Waiver training required of all residential provider staff.

Quality of Care Recommendation B.2.c: It is recommended that DMHMRSAS revise licensure requirements for group home and sponsored family placements to require certification by the provider that each staff member has completed training in person-centered planning, choice, self-determination, and the role of staff as supporters and teachers of learning using an approved training module.

DMHMRSAS Response: *Licensure regulations will be revised during the fall of 2006 and will include language (subject to the normal regulatory revision procedures) stipulating a requirement for a minimum level of training for all staff in the principles, values, and techniques of person-centered planning, choice, self-determination, and the role of staff as supporters and teachers of learning using a DMHMRSAS approved training module.*

C. Community participation and integration

Along with choice, community integration – for work, shopping, and recreation - is a major component of good quality of life. The formation of valued relationships with persons in the community - other than those paid to work with the residents - is key.

Quality of Care Finding C.1: All community-based residents have frequent and regular activities away from their homes and out in the community for work, shopping, and recreation.

- 49 % of community residences were rated as accessible to community resources, with a clear pattern of frequent involvement. 49 % of sites were rated as having community activity, but less often and usually only in groups and on agency vans in organized activities.
- Almost all residents of community programs leave their homes nearly every day for work or day activity out in the community. Only 7 % stay in their homes for day activities, and some of these remain at home by choice with the support of staff who respect the stated desire of specific consumers not to work.
- 79 % of families and 86 % of case managers are satisfied with the opportunities for community involvement and use of community resources that are afforded to the resident they know.

No recommendations

Quality of Care Finding C.2: Smaller residences, especially sponsored placements, have better levels of community participation for residents than larger group homes.

- Sponsored family placements featured the most integrated community experience of all settings. As part of a small family setting, the one or two residents in the

sponsored placement enjoys essentially normal community involvement, going out with the family as a family.
- Residents in sponsored placements were observed to have greater choice than group home residents.

No recommendations

Quality of Care Finding C.3: While all homes help residents get out to the community for work, shopping, church, recreation and other activities, reliance in group homes on group activities decreases the opportunities for true integration and formation of valued relationships with people other than paid staff.

- The most commonly noted community activity involves all the residents of the home traveling to a community event in a van or two cars, usually accompanied by two staff. Providers recognize the integration limitations of such group activities but say that budgets are inadequate to hire sufficient staff for one-to-one or very small group activities. Many providers said that low Medicaid waiver rates restrict staffing options and decrease community participation as a result.
- In response to interview questions, very few residents were able to cite community visits to or from persons (other than families), suggesting few people have been able to develop valued relationships with persons other than family or persons paid to be with them.
- Almost no records show involvement of "natural supports" (e.g., friends, bosses, neighbors - people with whom the resident has valued relationships) in the development of the services plan.

Quality of Care Recommendation C.3: It is recommended that DMHMRSAS initiate a study with DMAS, CSBs and private providers to determine the optimal size, characteristics, and staffing patterns of residential services hat have been found to be effective in promoting full integration of residents into the community and good quality of life. This study should identify what changes in state policy and funding would be required to support the widespread development of such programs in Virginia.

DMHMRSAS Response: *DMAS, DMHMRSAS, CSBs, private providers, and other stakeholders, will be conducting a study/review of the MR Waiver beginning in the summer of 2006. This recommendation will be included as a part of that comprehensive review. In addition, the Council on Quality and Leadership will be presenting the "social capacity index" on June 27, 2006 to DMHMRSAS and DMAS staff as a possible model for evaluating the quality of life for persons receiving services. If adopted for use in Virginia, this instrument may be useful in developing and shaping the best practice models of residential services.*

D. Culture of support for growth and development

Good quality of life requires community living skills. Effective residential services provide training that enhances and grows these skills to enable the highest level of

independence possible. Staff practices that teach and support residents to master skills are valued over approaches that provide static care, no matter how loving. Training programs should be based on thorough assessments of skills needed to live more independently. Staff should have personal interest in and knowledge of the persons for whom they provide supports.

Quality of Care Finding D.1: While a significant number of staff in group homes and community placements interact with residents as teachers and supporters of learning, the majority relate as caretakers or supervisors.

- OIG inspectors observed staff/resident interaction at all homes. In 47 %, staff was judged to be in a teacher and supporter of learning role that enables individuals to grow and reach their potential for self-determination. In 50 %, staff was seen in provider and caretaker roles, which are foundational, but not adequate to enable growth. 3 % of staff were not interacting with residents but were watching TV, visiting with other staff, or allowing non-adaptive or disruptive behaviors to persist.
- Staff members were asked what are the mission and values of the program. Among direct service staff, 33 % gave responses that were strong on choice, empowerment, self-determination, and progress toward independence, along with positive statements about dignity and respect. 65 % gave responses that were positive and respectful of residents, but limited to statements such as "treat with dignity and respect" or "provide care that I would want for myself."
- 81 % of families and 89 % of case managers think the program has helped the resident achieve planned goals over the past year.

Quality of Care Recommendation D.1: It is recommended that each CSB and private provider of residential services review it's mission statement and value statements and make any changes needed to assure consistency with the system wide vision statement adopted recently by DMHMRSAS. Once this is done, each CSB and private provider should take the necessary steps to assure that the actions of staff at all levels and the culture of the program reflect the organizational mission and value statements.

DMHMRSAS Response: *Training initiatives addressed in B.2.b. will lay groundwork for the development of the system's culture of values to be consistence with those expressed in the DMHMRSAS vision statement. All providers of services will be asked, through this training process, to reconcile their agency's mission and vision with the DMHMRSAS vision and values statements. DMHMRSAS will work to identify tools that have been validated for measuring provider consistency with the values of self-determination, empowerment, and recovery and work with stakeholders to identify position description language that would reflect an expectation of these values being honored in day-to-day activities.*

Quality of Care Recommendation B.2.a, B.2.b and B.2.c are in support of this finding.

Quality of Care Finding D.2: Residents are treated with dignity and respect.

- 97 % of case managers and 95 % of family members or authorized representatives think that consumers are treated with dignity, respect, and courtesy at their residence.
- OIG staff observed nearly uniform treatment with dignity and respect and very often witnessed moving, sincere examples of these principles at work.

No recommendations

Quality of Care Finding D.3: Staff and provider agencies show interest in the residents and are committed to their work.

- Families and case managers were asked if staff at the residence understand the resident's needs. 87 % of families responded yes, as did 93 % of case managers.
- Asking staff if they know a given consumer's birthday was devised as a measure of staff knowledge and interest in the consumers they serve. 54 % of staff knew the selected consumer's birthday and talked about how it was observed with some detail and enthusiasm.
- Another related measure was staff commitment to their jobs and to the residents. As suggested by a provider during the design phase of this project, staff and providers were asked to "tell a story" about how their job gives them meaning or a sense of accomplishment. 76 % of staff and 81 % of providers answered with detailed, often moving stories of residents or events that demonstrated real commitment to their jobs and their residents.

No recommendations

Quality of Care Finding D.4: The comprehensiveness and quality of residents' needs assessments and service plans varies considerably among community residential providers. Many plans and activities are not clearly directed at improved quality of life and greater independence for residents.

- 59 % of community programs were judged to have comprehensive needs assessments, addressing all life skill domains and including at least some assessment of residents' preferences.
- 63 % of surveyed programs demonstrated a high degree of involvement of appropriate persons, including residents, families, and other providers in the development of the assessment and plan. 30 % showed some involvement of appropriate persons.
- The goals of many programs focus on short-term activities, often centered on personal care, laundry, and housekeeping skills. Visions of higher levels of independence and self-determination are often not evident, nor is it clear how the current activities will help the resident move in this direction.
- Few plans are strong on resident choice; none are truly resident-directed.

- Resident plans, planned activities, and observed activities are not found to be distinctive and individualized among residents at group homes. Most consumers' plans are more like everyone else's in the residence than different.
- Coordinated, interdisciplinary team assessments featuring the insights of specialists such as psychologists, psychiatrists, medical doctors, nursing, physical and occupational therapists, nutritionists, speech and language specialists, etc. are very rare in community programs. When such assessments are found in the record, they have often been forwarded from training centers or public schools and sometimes are outdated.
- No two providers use the same packages of assessment tools, planning approaches, or forms.
- Because community providers use different assessment tools, planning approaches, and forms and there is no consistency among the training center instruments and processes, compilation of meaningful comparative data regarding the system of services is severely hampered.

Quality of Care Recommendation D.4.a: It is recommended that DMHMRSAS initiate a collaborative study with CSBs and private providers to:

- Define and quantify the staff resources that are needed to support adequate interdisciplinary assessment and planning for the residents of public and private community-based residential services.
- Develop models for how these services can be delivered collaboratively by CSBs, private providers, training centers, and/or universities.

DMHMRSAS Response: *The DMHMRSAS will initiate a study to be conducted through the The Advisory Consortium on Intellectual disabilities (TACID), formerly the MR Special Populations Work Group, on the resource needs for interdisciplinary assessment and planning in residential services and develop models for collaborative provision of services. This study will be completed by January 1, 2007.*

Quality of Care Recommendation D.4.b: Based on the results of this study, it is recommended that:

- Individual public and private providers and regional groups of public and private providers identify ways in which current resources can be redirected to provide interdisciplinary planning and assessment staffing.
- DMHMRSAS request sufficient funding to support these services.

DMHMRSAS Response: *Results of the study referenced in D.4.a will be produced for regional discussion and recommendations and then summarized in an "Advisory" to the DMHMRSAS for inclusion in the budget proposal for FY 2008.*

Quality of Care Recommendations B.2.a and B.2.b. are in support of this finding.

Quality of Care Finding D.5: Providers and direct support staff have appropriate education, experience, and longevity to support quality services.

- 96 % of direct support staff have some college education or at least a high school diploma. Only 4 % have less than a high school education.
- Among providers representatives (supervisors, directors, owners) 40 % have masters or doctoral degrees, and 50 % have BA degrees.
- 72 % of provider representatives have over 10 years of experience in the mental retardation field.
- 38 % of direct support staff has over six years of total mental retardation experience. 35 % have between one and six years experience, and. 27 % have less than one year or experience,
- 17% of direct support staff has over six years of experience in the specific homes visited, often with the same residents. 61 % has between one and six years in the home. Only 23 % has less than one year of experience.
- Families and case managers do not identify frequent staff turnover as a major problem, but some concerns exist. 48 % of family/AR's and 65 % of case managers said frequent staff turnover is not a problem for the residents, but 39 % and 31 %, respectively, identify some degree of difficulty due to turnover.

No recommendations

E. Comfort and Privacy

Comfortable, attractive homes are essential to good quality of life. Privacy, space to one's self, and personal decorations and furnishings are key components. A private bedroom for each person is highly desirable, unless specific, resident-generated choices are for shared living arrangements.

Quality of Care Finding E.1: Community residential programs are comfortable and attractively furnished.

- 73 % of homes are attractively furnished and present a warm, comfortable, non-institutional environment. 20 % show minor deficiencies or wear. Only 7 % were judged to be dirty or poorly maintained. Some homes show sensitivity by separating office space and areas where records and medications are stored from living areas; some do not.
- Inspectors noted that the warmth and personalization of residents' rooms varied almost directly with involvement by family members. For those residents who do not have involved family or resources, some providers purchase resident-chosen decorations and personal items with agency or resident funds. In those homes where the providers do not provide this assistance, the barren, impersonal rooms are a stark reminder of the lack of natural supports for many residents.

No recommendations

Quality of Care Finding E.2: Most community group homes and sponsored placements have a satisfactory level of privacy for residents.

- 74 % of group homes and 84% of sponsored family placements offer private bedrooms for all residents.
- Other provisions for privacy (doors on bathrooms, curtains, space for private belongings, etc.) are present in all community homes.
- Staff were nearly uniformly observed to respect privacy and dignity in interactions with residents.

No recommendations

F. Assurance of accountability and oversight

Families and taxpayers should have assurances that publicly funded services for persons with mental retardation and related needs are safe, compliant with regulatory and funding source requirements, and deliver quality services.

Quality of Care Finding F.1: Oversight activity at group homes and sponsored placements by state oversight offices/agencies is limited due to the staffing constraints.

- Several state agencies and offices provide varying types of oversight for group homes and sponsored placements, with some degree of coordination. Oversight responsibilities for each of these entities is broader than just community residential services for adults with mental retardation:

Oversight Entity	Focus of Oversight	FTEs	Method
DMHMRSAS Office of Licensing	Compliance with licensure regulations – all licensed MH/MR/SA programs, all types of services	15	- periodic unannounced visits - response to complaints
DMAS Quality Management Review	Compliance with policy and funding requirements – all Medicaid waiver programs	12	- periodic unannounced visits to sample of providers
DMHMRSAS Office of Human Rights	Compliance with human rights regulations - all licensed MH/MR/SA programs, all types of services	24	- response to complaints
Virginia Office for Protection and Advocacy (VOPA)	Protection of rights and advocacy – all persons with disabilities	42	- annual focus/plan - response to complaints
OIG	Quality of DMHMRSAS operated and licensed programs	3	- annual unannounced inspections of all DMHMRSAS operated facilities - inspection of licensed

			public and private providers including Dept of Corrections mental health treatment units

- The scope of oversight responsibilities for the DMHMRSAS Office of Licensure and the DMAS Long-Term Care Section has increased steadily as the number of services reimbursed by the Mental Retardation Medicaid Home and Community-Based Waiver has expanded dramatically over the past decade. The number of licensed group homes expanded from 342 in FY 2001 to 719 in FY 2005.
    - The goal of the office is to conduct at least one visit to each provider during the term of the license. The DMHMRSAS Office of Licensure staffing increased from 11 to 15 between FY 2001 to FY 2005 in order to enable this office to add brain injury services to it's scope of responsibilities. The Governor's FY2006-2008 proposed budget includes funding for 3 additional licensure specialists.
    - DMAS requested four additional Medical Facility Inspectors in Long-Term Care to conduct utilization review for Home and Community-Based Care Waivers in the FY2006 session of the General Assembly.
- The following chart documents the increases in unannounced group home inspections and complaints received by the DMHMRSAS Office of Licensure over the past five years.

Fiscal Year	Licensed Homes	Unannounced Inspections	Complaints
FY 01	342	108	93
FY 02		148	109
FY 03		233	108
FY 04		477	127
FY 05	719	648	132

- In response to questions by OIG inspectors, very few group homes and sponsored placements reported receiving recent visits from any of the oversight agencies listed above. OIG visits to group homes and sponsored family placements were made in the late afternoon, evenings and weekends.
- 91 % of families and 97 % of case managers reported general satisfaction with group home services currently received. However, many family members and case managers reported having complaints about other group homes where consumers had previously been served.
- The vast majority of activities by oversight offices/agencies focus on compliance with standards that are intended to establish a foundation for quality services but are not designed to access the actual quality of services being delivered.

Quality of Care Recommendation F.1.a: It is recommended that DMHMRSAS and DMAS continue to request resources to expand staffing in their respective oversight offices in order to assure regular and timely inspections of all licensed providers.

DMHMRSAS Response: *A recent reconfiguration of DMAS' quality management review unit provides a team of 10 analysts to conduct oversight and review of MR Waiver services. This approach incorporates a comprehensive assessment of waiver services related to CMS' Quality Framework assurances, in addition to regulatory and provider enrollment requirements.*

DMHMRSAS will continue to request positions for monitoring licensure and human rights activities in the Commonwealth and for training providers and monitoring all facets the Waiver process.

Quality of Care Recommendation F.1.b: It is recommended that as DMHMRSAS and DMAS review and amend their respective regulations and inspection procedures that they seek ways to:

- Incorporate the vision and values that have been established by DMHMRSAS for the system of care.
- Expand the focus of oversight activities related to assessment of consumer quality of life.
- Assure consistency between the regulations and procedures of the two agencies.
- Streamline and minimize data and record keeping requirements in an effort to allow providers to maximize the amount of time that staff is available to consumers.

DMHMRSAS Response: *DMHMRSAS and DMAS are presently updating their interagency agreement and DMHMRSAS will seek every opportunity to incorporate our vision and values in this agreement.*

DMHMRSAS is presently collaborating with DMAS in developing Virginia's plan for compliance with the Center for Medicaid and Medicare Services (CMS) Quality Framework guidelines, which includes a focus on the quality of life concerns noted in the OIG review. The quality management review of MR Waiver services and providers incorporates an assessment of consumer quality of life, as it relates to these Quality Framework assurances. This recommendation can be assured in this summer's comprehensive review of the MR Waiver in collaboration with DMAS, DMHMRSAS, and other stakeholders. This collaborative effort will also be used to identify and address inconsistency in DMHMRSAS and DMAS regulations.

The Commissioners of DMHMRSAS and DMAS established a Consumer Records Workgroup in the Spring of 05, comprised of members from the Virginia Association of Community Services Boards, the Department of Mental Health, Mental Retardation and Substance Abuse Services, and the Department of Medical Assistance Services to identify opportunities for streamlining documentation requirements for provides and the workgroup has issued a Phase One report of recommendations.

Quality of Care Finding F.2: Many CSB case managers do not make regular visits to consumers in their group homes or sponsored family placement settings.

- CSB case managers are required to develop annual plans for services for individuals with mental retardation. Medicaid requires that the case managers have at least one face-to-face contact with each consumer every 90 days and other contacts at least monthly. The case managers provide for coordination of services and advocacy for their needs.
- While CSB case managers have regular contact with those who are on their caseloads, many group home and sponsored family placement providers report that these contacts are made in day programs or outpatient offices with relatively few visits to the residential setting. Contact with the residential provider is often maintained by phone and at the time of the annual review of the service plan.

  Quality of Care Recommendation F2: It is recommended that CSB case managers visit with their consumers in the group home or sponsored family placement setting on a regular basis and make an assessments of:
  - The services provided by the provider.
  - The quality of life of the consumer.

  DMHMRSAS Response: *The DMHMRSAS is reviewing the role of case management through a special Case Management Best Practices Work Group. Recommendations for changes to requirements for case management from this work group will be incorporated into the licensure recommendations under review in the fall of 2006.*

  As DMAS and DMHMRSAS move toward the implementation of a comprehensive quality management strategy for Virginia's MR Waiver, the role of case managers will be instrumental in providing evidence to CMS on the quality of services. Case managers having direct observation of consumers' quality of life and the quality of services delivered by providers are directly tied to Virginia's demonstration of the Quality Framework assurances.

Section V

Appendix

A. Quality Statements and Indicators

B. Listing of Providers Reviewed

C. Description of Survey Questionnaires and Checklists
(Actual documents are available with the website version of this report found at www.oig.virginia.gov)

1. Consumer Profile
2. Environmental Checklist
3. Consumer Survey
4. Staff Survey
5. Provider Interview
6. Case Manager/Family or Authorized Representative Interview
7. Residential Record Review

Appendix A

Office of the Inspector General
For Mental Health, Mental Retardation, and Substance Abuse Services

Quality Statements for Mental Retardation Community-Based Residential and Training Center Services

1. The home is safe, clean, attractive, and comfortable.

Indicators:

- Residents are safe and protected from harm. Residents, families, staff, and case managers concur in this judgment.
- The home is clean and well maintained.
- The home is attractively furnished and comfortable.
- Residents are able to express their taste and choice of furniture, furnishings, and decorations in both their own living space and common space.
- The home looks like a home, not a residential program or ”homelike” environment.

2. Preventive, acute and chronic health needs of residents are met in a thorough, comprehensive, and safe manner.

Indicators:

- Residents have annual health assessments that are comprehensive and thorough.
- Residents have all necessary access to healthcare specialists.
- Emergency medical needs are met by qualified staff, and appropriate procedures are in place.
- Medications are stored, managed, and delivered in a safe and appropriate manner.
- Medical care is integrated and coordinated.
- Residents have regular dental checkups and dental needs are met.

3. Residents have choice and self-determination in all aspects of their lives.

Indicators:

- Residents have choice in the selection of their residence, room, and whether and whom they have as a roommate.
- Residents have choice in assessing their needs, goals, and activities through a system of planning that is person-centered.
- Support staff recognizes the primacy of resident choice and are trained and skilled in facilitating maximum possible choice for persons, regardless of the resident’s cognitive or communication limitations.
- Residents have choice in daily activities, meal planning, and use of leisure time.

- Residences afford people a level of privacy that we expect for ourselves: a room to ourselves, unless we choose to share it with someone else, space to be alone if desired, and provision to protect personal items.

4. Residents enjoy a high level of community participation.

Indicators:

- Residences are integrated into communities in a normal, non-stigmatizing way.
- Residence locations afford convenient and normal interactions with community services and neighbors.
- Residents experience daily participation in the everyday routine of community living: work, shopping, recreation, civic and religious activities if chosen.
- Resident participation in the community is in the smallest possible group considering safety and resident preference.
- Residents form meaningful relationships with persons in the community other than their families and persons paid to be with them.

5. Residents are supported to learn the skills they need to achieve their goals and participate in the community at the highest level of quality of life possible.

Indicators:

- The provider agency is guided by a mission and system of values that endorse self-determination, development, and a good quality of life for residents. Staff at all levels understand and are guided by the mission and values.
- Staff interacts with residents as teachers and supporters of learning.
- Residents are treated with dignity and respect.
- Staff are committed to the support of residents and are qualified to help residents achieve their goals.
- Residents know staff; staff know residents; and the disruption of frequent staff turnover is minimized.
- Comprehensive information is collected concerning each person's preferences, personal goals, needs and abilities, health status, and other available supports.
- Information is obtained from a variety of sources including the consumer, the consumer's natural supports, family or legally authorized representative, case manager, and other service providers.
- There is evidence that assessments, goals, objectives and activities are linked in a logical, consistent and thorough manner.
- Goals are set to advance growth and development toward ever higher levels of quality of life, community participation, and independence.
- Services and supports are integrated across service systems within the facility and in the community.

*6. Accountability for not only compliance with standards but also the quality of services is assured.

Indicators:

- Oversight authorities must be strong enough to assure compliance with all regulations.
- Oversight should include measures of quality of life.
- Provider practices should be evidence-based and state of the art.
- Regardless of the location or wealth of a community, publicly funded services should be equitably available to all Virginians.

* Note: These six Quality Statements were developed for the review of community residences and the five training centers. However, the review of the training centers did not include the sixth statement that deals with accountability and oversight.

Appendix B

Listing of Providers Reviewed

Licensed Providers of Group Homes Selected for OIG Review

Alexandria Community Services Board
Beetween The T`s, LLC
Blue Ridge Group Home, Inc
Central Virginia Community Services
Chesterfield Community Services Board (2)
Chimes Virginia, Inc
Community Alternatives, Inc. (2)
Community Living Alternatives, Corp
Community Living Services
Community Residences, Inc.
Community Systems, Inc.
Community-Based Services, Inc.
Consumers Have Opportunities in Community Experience
Crossroads Community Services Board
Cumberland Mountain Community Services
Danville-Pittsylvania Community Services
DePaul Family Services
Fairfax - Falls Church Community Services
Faith Partners Care Group, Inc.
Family Life Services, LLC
Fidura & Associates, Inc. (2)
Grafton Inc.
Halo, Inc.
Hampton-Newport News Community Services
Hartwood Foundation, Inc.
Heart Havens, Inc.
Henrico Area Mental Health & Retardation Services
Insight, Inc.
Inspiration House
J and D Residential Services, Inc.
Lamano Agency, Inc.
Loudoun County Community Services Board
Louise W. Eggleston Center
Lucas Lodge, LLC
Middle Peninsula-Northern Neck CSB
Negril Inc. - R.C. Right`s Group Home
New Roads, Inc.
NHS Mid-Atlantic, Inc.
Phoenix Aspiration System of Care, LLC
Piedmont Community Services

Pleasant View, Inc.
Positive Options in Living, LLC
Rappahannock Area Community Services Board
Region Ten Community Services Board (2)
Rehobeth Residence, Inc.
Rivers Assisted Living Services
St. John's Community Services-Virginia
Support Services of Virginia, Inc.
The ARC of the Virginia Peninsula, INC.
The ARC of the Piedmont, Inc.
The Brambles
Virginia Baptist Children's Home & Family Services, Inc.
Virginia Beach Department of Human Services
Volunteers of America - Chesapeake, Inc.
Wall Residences, LLC (2)
Warrington Investments, LLC
Western Tidewater Community Services Board

MR Sponsored Family Home Providers Selected for OIG Review

Blue Ridge Residential Services
Cabaniss Consultants, LLC
Chesterfield Community Services Board
DePaul Family Services
Fairfax - Falls Church Services Board
Lamano Agency, Inc.
Loudoun County Services Board
Mount Rogers Community MH & MR Services Board
Rappahannock Area Community Services Board
Rappahannock-Rapidan Community Services Board
Richmond Residential Services, Inc.
Valley Community Services Board
Wall Residences, LLC

Note: If the OIG conducted an inspection at more than one program site operated by a single provider, the number of sites visited is noted in parenthesis.

Appendix C

Survey Instruments

Office of Inspector General Review
Community Residential Services and Training Centers
For Adults with Mental Retardation

Office of the Inspector General (OIG) staff developed structured interview instruments that addressed each of the indicators in the quality statements, many from more than one point of view. Where possible, these interview instruments were based on questionnaires or other evaluation tools found in the professional and consumer literature or tools that had been used before in Virginia. Examples of existing Virginia survey instruments that were sampled include the DMHMRSAS Family Satisfaction Survey and the survey instruments developed by the Citizens' Monitoring Program, a family-driven mental retardation quality survey team sponsored by the Virginia Beach Community Services Board. A brief description of each survey questionnaire and checklist is provided below. A copy of each document can be found on the website version of this report at www.oig.virginia.gov.

Consumer Profile – A 24-item questionnaire that draws demographic and level of functioning of residents from records. Completed for all review participants at each site or unit.

Residential Record Review – A 10-item questionnaire that evaluates the quality of the written individualized services record at the residence. Completed for a sample subset of the review population selected for intensive review.

Consumer Survey – A 13-item questionnaire that seeks opinions and preferences through a confidential face-to-face interview with residents in the sample subset.

Environmental Observation Sheet – A 17-item observation checklist that evaluates the living environment of the residential site. Completed for all the community sites visited and the units of the state training centers where the intensive study sample population resides.

Staff Survey - A 19-item questionnaire that evaluates staff knowledge, values, practices, and opinions in a confidential interview at the residence. Completed for one randomly selected staff member per consumer selected for intensive review at each site or unit.

Case Manager/Family-Authorized Representative (AR) Interview - An 18-item questionnaire that assesses involvement and satisfaction with residential care through a confidential telephone interview. Completed for both the case manager and family or AR of each of the residents selected for intensive review.

Provider Interview – A 16-item questionnaire that assesses knowledge, values, and experience of representatives of the provider organization. Completed for each community residential site and each training center by confidential telephone interview with a person designated as residential services director for the provider organization.

CONSUMER PROFILE

1. PROVIDER: State Operated Facility / Public Community / Private Community

2. FACILITY: _____ 3. UNIT: _____

4. CONSUMER'S NAME: _____

5. DOB: _____ 6. Age: _____ 7. Gender: M F

8. Date of Admission _____ 9. Length of Stay: _____

9. CSB Casemanagement: _____

10. Case Manager's Name and Phone #: _____

11. AR or family member's Name and #: _____

Date _____ OIG Staff _____

12. IQ:

___Mild (50-70) ___Moderate (35-49) ___Severe (20-34) ___Profound (below 20)

13. Co-occurring Disabilities:

___Visual Impairment ___Hearing Impairment ___Cerebral Palsy
___Muscular Dystrophy ____Autism _____Epilepsy ___Other _____ None

14. Co-occurring Psychiatric Disorder:

___Mood DO ___Anxiety DO ___Psychotic DO ___Other Disorder ___None

15. Number of chronic health problems: ____None ____1-3 ____4-6 ____7+

16. Currently on Medications: None ___ How many? _____

17. Currently on Medications for Behavioral Management: Y N

18. Level of Support:

___Intermittent (episodic) ___Limited support (needed for sporadic periods of time)

___Extensive (regularly needed for extended period of time) ___Pervasive (intensive and lifelong)

19. Mobility:

____ Independent ____ needs occasional assistance____ needs regular assistance

____ needs extensive assistance____ totally dependent on others for mobility

20. Currently has/uses a protective restraint: Y N

21. Day Activity:

___ Participates in a day program on campus

___ Participates in a community based day program

___ Participates in supported employment on campus

___Participates in supported employment in the community

___Involved in inclusive work for 10 or more hours every two weeks

Location: _____

22. Service Plan is Current: Y N

23. Level of Adaptive Functioning:

Area of Functioning	Met	Not Met	Measure of Functioning	Score
1. Health Status			2 or more answered with a 4	
2. Communication			3 or more answered with a 3 or 4	
3. Tasks Learning Skills			3 or more answered with a 3 or 4	
4. Personal / Self Care			Answered a with a 4 or 5 Answered b with a 4 or 5 Answered c and d with a 4 or 5	
5. Mobility			Any one answered with a 4 or 5	
6. Behavior			Any one answered with a 4 or 5	
7. Community Living Skills			Any 2 of b, e, or g answered with a 4 or 5 3 or more questions answered with a 4 or 5	
TOTALS				

24. Ready for discharge?__ yes__ no **25.** AR agree to comm placement ___yes____ no

MR RESIDENTIAL RECORD REVIEWS

FACILITY: _____ DATE: _____

Provider: _____

State Operated Facility/Public Community/Private Community (circle one)

Location: _____

Consumer's Name and Unique Identifier: _____

Reviewer: _____

ASSESSMENTS	Comments	Rating
1. Comprehensive information is gathered regarding consumer's: ___ Preferences ___ Health Status ___ Mental Health Needs ___ Personal Goals ___ Support Needs		1 – Thorough assessment, detailed and individualized for each domain 2 – Adequate assessment, addresses all domains 3 – Sparse detailed, undifferentiated information, misses one or more domains
2. Information is collected from a variety of sources: ___ Consumer ___Natural Supports ___AR ___Case Manager ___Service Providers(e.g. day support) ___Professional Assessments		1 – Info collected from all or most sources, including consumer and AR/family. 2 – Info was collected from consumer, AR/family, and one other source. 3 – no evidence of input from consumer and AR/family.

SERVICE AND SUPPORT PLAN		
3 .There is evidence that assessments, goals, objectives, and activities are linked in a logical, consistent and thorough manner.		1 - "Golden thread" clearly links all elements, logic is apparent and consistent 2 – Elements are supportable, related, but not as clearly linked 3 – Elements of plan are disjointed, not supported by assessments, not logically linked, inconsistent
4. Individual support plans address: ___Preferences ___Personal goals ___Needs ___Abilities/Strengths ___Health issues when present		1 – All domains thoroughly addressed 2 – Most domains addressed adequately 3 – Few domains adequately addressed
PROGRESS REVIEWS	**Comments**	**Ratings**
5. Changes in the consumer's needs trigger prompt revision of the treatment plan.		1 – Yes 2 – No
6. Goals, objectives and activities are progressive.		1 - Record uses language of progressive development, specific goals seek real progress 2 - General, unspecific, but developmental goals 3 – Maintenance goals
7. There is evidence that both acute and chronic healthcare needs are addressed, including dental care, annual physicals, medication follow-up visits and preventative testing which is age and/or gender		1 -Acute and chronic healthcare issues are addressed; all health domains addressed, followed up. 2-Substantial coverage

appropriate.		of a wide range of health needs, but some omissions or incomplete information, or gaps in documentation of follow up, timeliness. 3. Little comprehensive, current health information evident in residential record, unclear or inadequate picture of health needs or active health care.
8. The record reflects continuity of care across systems.		1. The record includes details of day support, case management, and other service plans and activities and there is congruence among them. 2. The residential record has partial or periodic references to other services and activities and these plans and activities are reasonably congruent. 3. There is little to no way residential staff are aware of or incoordination with other services by what is shown in the record and/or activities and plans are contradictory or inconsistent.
9. Evidence of CSB Case Manager Involvement		_____ Yes ____ No

Note: OIG Inspectors verified that dental services had been received within the last two years. Inspectors reported this information orally to the Project Manager.

CONSUMER SURVEY

Facility: _____ Reviewer: _____

Date: _____Consumer: _____

PROVIDER: State Operated Facility / Public Community / Private Community
Name of Provider: _____

Question	Responses / Other Comments	Ratings
1. Do you like living here?		1 Unsure 2 Unclear response 3 No response 4 Yes 5 No 6 Sometimes
2. Did you help pick this place to live?		1 Unsure 2 Unclear response 3 No response 4 Yes 5 No
3. Do you like the people you live with?		1 Unsure 2 Unclear response 3 No response 4 Yes 5 No 6 Sometimes
4. When you want something to eat (here at this residence), can you get it yourself anytime you want?		1 Unsure 2 Unclear response 3 No response 4 Yes 5 No 6 Sometimes
5. Can you go to bed whenever you want or stay up as late as you want?		1 Unsure 2 Unclear response 3 No response 4 Yes 5 No 6 Sometimes

6. Do the staff that work with you ask you what you would like to do?		1 Unsure 2 Unclear response 3 No response 4 Yes 5 No 6 Sometimes
7. Do the staff say “please” and “thank you” when they ask you for something?		1 Unsure 2 Unclear response 3 No response 4 Yes 5 No 6 Sometimes
8. Does anyone here at this residence ever do mean things to you such as yell at you?		1 Unsure 2 Unclear response 3 No response 4 Yes 5 No 6 Sometimes
9. Does anyone here at this residence ever hit you or hurt your body?		1 Unsure 2 Unclear response 3 No response 4 Yes 5 No 6 Sometimes
10. Do you ever get to visit people outside this residence?		1 Unsure 2 Unclear response 3 No response 4 Yes 5 No 6 Sometimes
11. Do other people ever come here to visit you?		1 Unsure 2 Unclear response 3 No response 4 Yes 5 No 6 Sometimes
12. Do you get to choose what you want to do during the day?		1 Unsure 2 Unclear response 3 No response

		4 Yes 5 No 6 Sometimes
13. Do you feel safe here in this residence?		1 Unsure 2 Unclear response 3 No response 4 Yes 5 No 6 Sometimes

ENVIRONMENTAL OBSERVATION SHEET / Facility: _____ State Operated Facility/Public Community/Private Community
Date: _____ Time: _____ Shift: _____ Reviewer: _____

Level of Activities: ____Period of high activities (meals, bedtime, other transitions) ____Period of low activity (leisure period)

Observation	Comments	Ratings
1. Well-Maintained Clean, free of odor, temperatures are comfortable, well-lit, walls, paint and furniture in good condition, lawn and exterior neat and clean		1 - all good, high standards 2 – minor deficiencies, effort evident, but worn and inconsistent 3 – notable dirt, disorder, poor condition
2. Privacy for Consumers Coverage at windows allows for privacy, adequate private storage for belongings, hygiene items, and private bedrooms for each individual.		1 – all good, plus private BRs (unless BR shared by consumer choice) 2 – all good or adequate, semi-private BR 3 – any missing or inadequate items, more than 2/BR
3. Comfort and Attractiveness Residence is well decorated and comfortable. Lamps, plants, pictures, rugs, decorations, personal items are evident. Items are age-appropriate, resident-selected		1 – resident choice evident, attractive, cohesive, warm, well-chosen, complete furnishings 2 – effort evident, some homelike touches 3 –barren, utilitarian appearance, cold, few amenities or decorations.
4. Barrier Free Restrooms, kitchen facilities, and entrances are handicapped accessible.		1 – well designed, all aspects of accessibility addressed, integrated 2 – minimal standards met, add-ons 3 – limits to access to essential living functions

5. Community Access Residence is conveniently accessible to shopping, dining, churches, and other activities.		1 – Accessible to residents by short walk, alone or in small numbers. Clear pattern of frequent resident involvement in the community, especially on their own or in very small groups. 2 – van or organized activity only. Some community activity, but usually in groups. 3 – isolated or non-residential neighborhood, infrequent outings – group only, little evidence of community involvement
6. Staff-Resident Interaction Pattern Staff are actively engaged with residents in supportive, enabling roles.		1 – Staff engaged with residents most of the time, staff in support, not caretaker roles, activities have developmental direction and purpose, enjoyable to residents. 2 – Staff are engaged with residents much of the time but are in provider/caretaker/supervisory role, activities may be non-developmental 3 – Little staff interaction, limited activities, residents watching TV, non-adaptive or disruptive behaviors

7. Presence of Individualized Service Plan The residents' comprehensive ISPs or an extensive copy thereof is located in the residence, with access by all direct service staff ; staff are familiar with it.		1 – Full or comprehensive record is easily accessible; direct support providers frequently reference it and add their contributions 2. - An abridged record is present, but direct support staff infrequently access or use it 3 – No comprehensive record present, or staff do not access it, are not familiar with it.
8. Licensed or Bed Capacity		1 – two or fewer residents at one site 2 – three to five residents at one site 3 – six or more residents at one site
9. Census at the time of the inspection		
10. Number of staff on duty (Count supervisor only if regularly scheduled and involved in direct care)		
11. Staff to consumer ratio (If fraction round up to next highest whole number)		1 – 1:1 or greater 2 – 1:2 to 1:3 3. – 1:4 or greater
12. Evidence of Choice for Consumers		1 – Consumers have choice or opportunity to choose activities, meals, snacks, bed time, participation level. 2 – Staff invite choice between limited options, for certain decisions, some of the

		time 3 - Little evidence of consumer choice, activities planned mostly by staff, limited options for choice
13. Evidence of staff communications regarding changes in the consumer's status or significant events (among shifts and among programs e.g. day support and case management, etc.)		1 – There is an established procedure for providing communication regarding significant changes in the consumer's status 2 – Staff informally leave notes or have verbal exchanges of significant events, changes or other issues that need to be shared 3- There little expectation or process for sharing information regarding significant changes in the consumer's status.
14. Consumers are assisted in managing medications in a safe and effective manner.		1 -There is an established procedure for safely handling, storing, and documenting the administration of medications that incorporates consumer preference and need. 2 There is an informal process for safely handling, storing, and documenting the administration of medications with limited focus on consumer preference and need. 3. Medication usage and administration is not tracked or stored in a safe and effective manner.

Staffing and Resident Activities (FACILITY ONLY)

1. Number of staff responsible for 1:1 coverage during the shift: _____

2. Number of residents on special hospitalization status: _____

3. List any scheduled activities for the residents during this shift, including off-site activities: _____

_____

Staff Survey

Facility: _____ Reviewer: _____

Date: _____Staff: _____

Supervisor or Direct Support Provider (circle one)

State Operated Facility/Public Community/Private Community (circle one)

Name of Provider Organization: _____

Consumer Name: _____

Question	Reviewer Comment	Responses
1. How long have you worked in this residence with these residents?		____ years ____ months
2. What is the mission or purpose of your agency? What is it trying to achieve? (DMHMRSAS vision) Consumer-focused and community based services and supports that promote self-determination, empowerment, recovery, resilience, health and the highest possible level of consumer participation in all aspects of community life including work, school, family, and other meaningful relationships.		1 – Uses language of choice, self-determination, integration, and progress toward independence. Quotes or paraphrases agency mission. 2 – Uses language of general good intentions, "treat with dignity and respect," etc. 3 – No answer, uncomfortable with concept, responds in caregiver, "take care of …" manner.
3. How does your facility expect you to behave toward the persons you serve and your fellow staff? What are your organization's values or guiding principles?		1 - Uses language of choice, empowerment, self determination, accountability, other references from DMHMRSAS Vision. Describes support role. 2 – Uses positive language of good intentions in a fairly cohesive response, e.g. treats with respect, provide good care, and keep safe. Describes care-giver role. 3 – Has no response, or very limited response, little evidence

		of thought or exposure to concepts

4. What is your highest level of education?		1 – Masters or BA in special education, social work, psychology, rehab counseling, etc. 2 – Some college in related field or high school graduation. 3. – Lower than high school graduation.
5. How long have you worked in the mental retardation field before you came to work in this residential program with these consumers?		_____ years _____ months
6. Are the consumers you serve in this program safe and protected from harm?		1 – Positive, confident answer, offering details or examples of why 2 – Vague or limited answer, positive but without confidence, feeling or details 3 – Negative answer or refusal to answer
7. Do you as an employee feel safe in this working environment?		1 – Positive, confident answer, offering details or examples of why 2 – Vague or limited answer, positive but without confidence, feeling or details 3 – Negative answer or refusal to answer
8. Who is involved in deciding what meals will be served?		1 – Response indicates consumers have individual or collective choice in an active, real fashion, knowledgeable about individual preferences. Decisions are substantially with the consumer(s). 2 - Input is sought, and preferences are known, but menus

		are decided by the program manager or staff here or elsewhere. 3 – Response is substantially insensitive to choice or preference. Preferences may be known, but they will seem to be irrelevant to what is done
9. Let's talk about ____. What is his birthday?		1 – Knows it, states it 2 – Recognizes importance, says what they do for birthday, but does not remember it 3 – No idea, does not suggest it is important to know.
10. Tell me a story about how this job has affected you or how you find meaning and satisfaction in this work		1 – Detailed , warm, enthusiastic response that focuses on consumer growth and development, shows joy or caring for job. 2 – Positive response, general in nature, shows some positive regard for the job. 3 – Negative, guarded, or no response
11. If _____ experienced some difficulties during the previous shift, how would you become aware of these concerns?		1 – Positive, confident answer, offering details or examples of ways communication occurs 2 – Vague or limited answer, positive but without confidence, feeling or details 3 – Negative answer or refusal to answer
12. What information is routinely shared with the other programs and services _____ is involved in?		1 – Positive, confident answer, offering details or examples of ways communication occurs 2 – Vague or limited answer, positive but without confidence, feeling or details 3 – Negative answer or refusal to answer

13. What are ____'s goals and plans and plans for himself/herself? What does **he/she** want?		1 – Positive, detailed answer that shows knowledge or imagines that ___ does indeed have a choice or goal for him/her self, or that we should seek to know it. 2 – Positive, but generic or non-specific goal, or a "comfort" goal or preference 3 – Negative response or statement that suggests such a thing is not possible, never thought about it, etc.
14. What are the main two goals in _____'s service plan?		1 – Detailed, confident, accurate answer that conforms with plan. 2 - Positive, generic answer, "to become more independent", to learn to dress himself" 3 – Don't know, non-developmental answer, etc.
15 How much did you have to do with the plans of the residents here?		1. describes, knowledgeable, involved role, active participant. 2. some involvement, passive, "they ask me about (the residents)," few specifics 3. Little to no involvement noted or apparent
Facility Staff Only		
16 During the past 12 months has there been any activity around redesigning or revising the facility's mission?		1. Positive, detailed answer that shows knowledge 2. Positive, but generic response 3. Shows little knowledge or unknown
17. What training have you received during the past year that has increased your use of positive behavioral supports?		1. Positive, detailed answer that shows knowledge 2. Positive, but generic response 3. Shows little knowledge or unknown

18. What efforts have occurred in the past 12 months to assess staff satisfaction?		1. Positive, detailed answer that shows knowledge 2. Positive, but generic response 3. Shows little knowledge or unknown
19. What efforts have occurred in the past 12 months to understand the level of satisfaction of other stakeholders?		1. Positive, detailed answer that shows knowledge 2. Positive, but generic response 3. Shows little knowledge or unknown

Case Manager/Authorized Representative or Family Interview

Facility: _____ Reviewer: _____

Date: _____Respondent:_____

Person Served: _____

Role (circle one): CSB case manager AR family member

PROVIDER: State Operated Facility / Public Community / Private Community

Name of Provider Organization: _____

Question	Comment	Ratings
1. How often do you visit to see _____ in the home?		1 – weekly 2 – monthly 3 – a few times a year 4 – less than once a year 5 – have never been there
2. Do you feel the place where _____ lives is a healthy and safe environment?		1 – yes/mostly 2 – Somewhat 3 – No, not at all 4 – Don't know
3. If the person does not speak English or uses a different way to communicate, do you feel that enough staff at the program know how to communicate with him?		1 – yes/mostly 2 – Somewhat 3 – No, not at all 4 – Don't know 5 – Does not apply
4. Do you feel that the services provided to ___		1 – yes/mostly

have helped him/her reach planned goals over the past year (or other period)?		2 – Somewhat 3 – No, not at all 4 – Don't know
5. Overall, are you satisfied with the services and supports that _____ receives at the residence?		1 – yes/mostly 2 – Somewhat 3 – No, not at all 4 – Don't know
6. Have frequent changes in the staff who work directly with _____ been a problem?		1 – yes/mostly 2 – Somewhat 3 – No, not at all 4 – Don't know
7. Do you feel that staff help _____ get out in the community often enough, take advantage of community resources such as recreation departments, churches, etc?		1 – yes/mostly 2 – Somewhat 3 – No, not at all 4 – Don't know
8. (for families and ARs only) Has the CSB case manager been helpful?		1 – yes/mostly 2 – Somewhat 3 – No, not at all 4 – Don't know
9. Do you have adequate participation in and communication about		1 – yes/mostly 2 – Somewhat

_____'s plans and service developments?		3 – No, not at all 4 – Don't know
10. Do you think that _____ gets enough say in developing his/her own plans and activities?		1 – yes/mostly 2 – Somewhat 3 – No, not at all 4 – Don't know
11. Do you think that the direct service staff who work with _____ are qualified for their jobs?		1 – yes/mostly 2 – Somewhat 3 – No, not at all 4 – Don't know
12. Do you think that the provider organization that operates _____'s residence are qualified and knowledgeable to operate such programs?		1 – yes/mostly 2 – Somewhat 3 – No, not at all 4 – Don't know
13. Upon admission, do you feel that you or _____ had adequate choice among providers or homes for _____?		1 – yes/mostly 2 – Somewhat 3 – No, not at all 4 – Don't know
14. Do you think the people who work directly with _____ understand his needs?		1 – yes/mostly 2 – Somewhat

		3 – No, not at all 4 – Don't know
15. Are you satisfied with how the program deals with complaints?		1 – yes/mostly 2 – Somewhat 3 – No, not at all 4 – Don't know 5 – Does not apply
16. Is _____ happy in his current residential placement?		1 – yes/mostly 2 – Somewhat 3 – No, not at all 4 – Don't know 5 – Does not apply
17. Do staff at the residential placement treat _____ with respect, dignity, and courtesy.		1 – yes/mostly 2 – Somewhat 3 – No, not at all 4 – Don't know 5 – Does not apply
18. If there is one thing you would change about the care _____ is receiving, what would it be?		

Provider Survey

Facility: _____ Reviewer: _____

Date: _____ Name of Provider: _____

Provider Representative:_____

Role: Owner Executive Director Program Manager Other (circle one)

PROVIDER: State Operated Facility / Public Community / Private Community

Question	Reviewer Comment	Responses
1. How long have you been associated with this provider?		____ years ____ months
2. What is the mission or purpose of your agency? What is it trying to achieve? (DMHMRSAS vision) Consumer-focused and community based services and supports that promote self-determination, empowerment, recovery, resilience, health and the highest possible level of consumer participation in all aspects of community life including work, school, family, and other meaningful relationships.		1 – Uses language of choice, self-determination, integration, and progress toward independence. Quotes or paraphrases agency mission. 2 – Uses language of general good intentions, "treat with dignity and respect," etc. 3 – No answer, uncomfortable with concept, responds in caregiver, "take care of …" manner.
3. How does your facility expect your staff to behave toward the persons you serve and your fellow staff? What are the organization's values or guiding principles?		1 - Uses language of choice, empowerment, self determination, accountability, other references from DMHMRSAS Vision. Describes support role. 2 – Uses positive language of good intentions in a fairly cohesive response, e.g. treat with respect, provide good care, keep safe. Describes care-giver role. 3 – Has no response, or very limited response, little evidence of thought or exposure to concepts

4. What is your highest level of education?		1 – Ph.D or Masters in special education, social work, psychology, rehab counseling, etc. 2 – BA degree in related field. 3. – High school graduation or lower.
5. How long have you worked in the mental retardation field overall?		_____ years _____ months
6. Are the consumers you serve in this program safe and protected from harm?		1 – Positive, confident answer, offering details or examples of why 2 – Vague or limited answer, positive but without confidence, feeling or details 3 – Negative answer or refusal to answer
7. Do your employees feel safe in this working environment?		1 – Positive, confident answer, offering details or examples of why 2 – Vague or limited answer, positive but without confidence, feeling or details 3 – Negative answer or refusal to answer
8. What do you do to assure that your programs are of the highest possible quality?		1 – Response describes active, varied program of continuous quality improvement; mentions specific tools, offers examples or results, includes consumer/family feedback. 2 – General, but positive answer; uses unannounced inspections, review of records, supervision, training 3. Poor or overly general response, no or few examples

9. How does your organization go about developing residents' individualized service plans?		1 – Positive, detailed answer that shows knowledge or imagines that consumers indeed have a choice or goal for him/her self, or that we should seek to know it. 2 – Positive, but generic or non-specific goal, or a "comfort" goal or preference 3 – Negative response or statement that suggests such a thing is not possible, never thought about it, etc.
10. Who is involved in deciding what meals will be served?		1 – Response indicates consumers have individual or collective choice in an active, real fashion, knowledgeable about individual preferences. Decisions are substantially with the consumer(s). 2 - Input is sought, and preferences are known, but menus are decided by the program manager or staff here or elsewhere. 3 – Response is substantially insensitive to choice or preference. Preferences may be known, but they will seem to be irrelevant to what is done
11. What changes would you wish to see in state policy or funding?		1 – raise Medicaid rates 2 – increase waiver slots 3 – other, list _____ _____ _____ _____

12. Tell me a story about how this job has affected you or how you find meaning and satisfaction in this work		1 – Detailed , warm, enthusiastic response that focuses on consumer growth and development, shows joy or caring for job. 2 – Positive response, general in nature, shows some positive regard for the job. 3 – Negative, guarded, or no response
13. What do you do to assure your residents are integrated into the community?		1 – Detailed, positive answer, multiple examples, includes use of community resources, individualization – clearly the intent of the program 2 – Positive response, some examples, more group outings than individual. 3 – Poor command of details, only group outings, little awareness of individual value
14. What choice do your consumers have in which residence they live or whether and who their roommate is?		1 – Positive, detailed answer that shows knowledge or imagines that consumers indeed have a choice on living arrangement and makes such choices. 2 – Positive, but generic or non-specific goal, "seeks agreement", tries to accommodate choices and gives example, but not always possible. 3 – Negative response or statement that suggests such a thing is not possible, never thought about it, etc. Explains how it can't work.
15. How do you assure that your residents have access to comprehensive medical care and, indeed, get good medical care?		1 – Detailed, positive, comprehensive, knowledgeable answer, multiple examples, includes use of community resources, including specialists, gives examples – coordination with case manager 2 – Positive response, some

		examples, acknowledges shared responsibility with CM, names general practitioner. 3 – Poor command of details, suggests it is case manager's responsibility, provides only emergency procedures, maybe names one M.D.
16. What role do your direct care staff have in developing and refining the individual service plans of the persons you serve.		1. Active, detailed involvement, examples cited, details value of direct care input, describes true team process. 2. general answer, "all staff participate," clinical leaders share plans with direct care staff 3. notes no role for direct care staff